



Collaborative Team Approach to Improved Diabetes Care

Cape Breton Health Transformation Office (CB HTO)
Diabetes Care Program of Nova Scotia (DCPNS)
Northside Diabetes Centre (NS DC)

Phillip Morehouse, Director
Health Transformation Office



Project Timelines

- January 2009 CBDHA "Draft" Diabetic 5 Year Strategic Plan
- May 2009 DCPNS Request for Proposals
- September 2009 Full Proposal Submission
- November 2009 Kick Off Meeting
- January 2010 Physician Meeting, Northside General Hospital
- March 2010 Patient Assessment 14/16
- April 2011 Pilot Complete
- September 2011 Pilot Evaluation



Goal

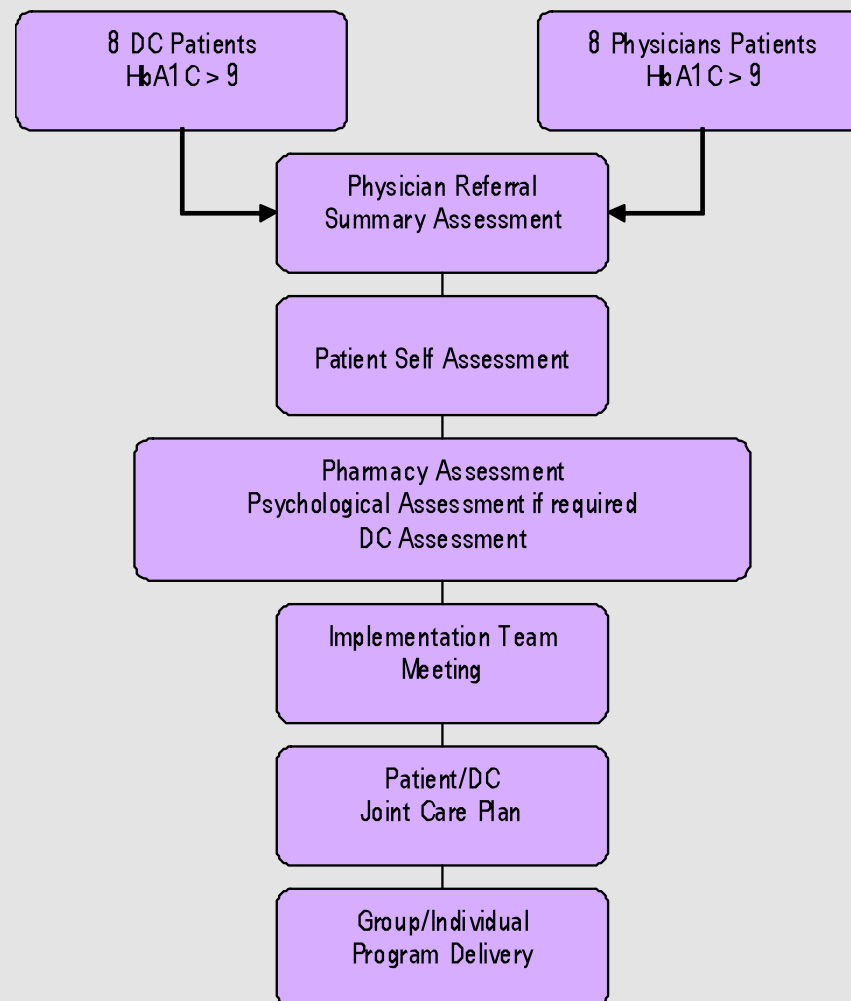
- Develop, implement and evaluate an enhanced team-based approach for patients with persistently high HbA₁C levels.
- Reduce HbA₁C levels by 10%
- Monitor and improve blood pressure, waist circumference, ↓ LDL, microalbumin, eGFR, ↑ physical activity, etc.



Advisory Committee Members

- Phillip Morehouse, Health Transformation
- Peggy Dunbar, Diabetes Care Program of NS
- Mary Beth LeBlanc, Coordinator, Policy, Planning and Evaluation
- Laurie Forrest, Health Transformation
- Alice Murphy, Diabetes Centre
- Patricia Kohlsmith, Diabetes Centre
- Dianne Smith, Physiotherapy
- Dr. Brenda Durdle, Psychology
- Dr. Joan Salah, Family Physician
- Dr. Deborah Zwicker, Endocrinologist
- Elaine Rankin, Population Health and Primary Care
- Frances Butler, Medical Social Work
- George Hatcher, Pharmacy
- Heather Duff, Nursing/Diabetes Centre
- Lorne MacLeod, Continuing Care

Process Chart





Implementation Team Members

- Alice Murphy, Diabetes Centre (*Case Manager*)
- Patricia Kohlsmith, Diabetes Centre (*Case Manager*)
- Dr. Brenda Durdle, Psychologist
- Diane Smith, Community OT/PT
- Frances Butler, Medical Social Worker
- George Hatcher, Pharmacist
- Dr. Joan Salah, Family Physician
- Physicians of Patients Referred from Physician's Offices
- Mary Beth LeBlanc, Coordinator, Policy, Planning and Evaluation
- Laurie Forrest, Health Transformation (*Project Manager*)
- Your Way to Wellness (*YW2W*) as required
- Continuing Care as required



Inclusion Criteria

- \geq 25 years of age and \leq 75
- Patient with diabetes, excluding gestationals
- Patient with A₁C persistently above 9%
- Patient of a North Sydney Physician



Exclusion Criteria

- Newly diagnosed diabetes (< 1 year ago)
- < 25 or over age > 75
- Pregnant women
- Patients who are cognitively impaired



Forms and Tools

For Patients new from FP (existing forms in use):

- Physician Referral to Diabetes Centre
- Diabetes Centre Self Assessment Form (medication sheet, food record, Diabetes Foot Care Questionnaire)

New Pilot Forms:

- Physician Referral to Diabetes Centre Re: DC Pilot Project
- Pilot Patient Self Assessment (series of questions)
- Pharmacy Self Assessment
- Pharmacy Medication Reconciliation
- Patient Summary Diabetes Centre Assessment (compiled findings)

Validated Scales:

- Diabetes Distress Scale
- Diabetes Quality of Life Questionnaire (QOL)
- HADS Assessment
- BDI Beck Hopelessness Scale (as required)
- BDI Beck Depression Scale (as required)

- 3 Minute Empowerment
- Options and Opportunities Concept (Individual/Group)



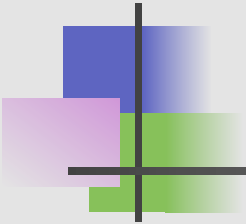
Evaluation

- Logic Model has been developed
- Patients, Case Managers and Multidisciplinary Team
- Patients with persistently high A1Cs will have improved outcomes and appropriate utilization of the Health Care System as a result of engagement with the Case Management and Multidisciplinary Team Approach.



Observations To Date

- Excellent collaboration in the team
- HbA₁C better than expected
- Majority of patients agreed to participate
- Preliminary HADS scores higher than expected
- Operational Challenges- Vacations, Workshops, etc



Thank you!